

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12945

12945

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered for use as the burial-transit permit. Then please remove carbon-paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours, after death.

1. PLACE OF DEATH a. COUNTY Talbot		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN 1b 4 1/2 da.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Queen Anne	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hosp. tal		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Church Hill		d. STREET ADDRESS 17 x 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) W. Edwin		4. DATE OF DEATH Atkinson		Month 11		Day 25		Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12 1920	9. AGE (in years lost birthday) 37 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Louis H. Atkinson		14. MOTHER'S MAIDEN NAME Florence Luther		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			Carcinomatosis 5 months			INTERVAL BETWEEN ONSET AND DEATH 5 months	
		(b) DUE TO Carcinoma of the stomach						5 months	
		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Dover		(County)	(State)
21. I certify that I attended the deceased from _____ November 20, 1958, to November 25, 1958, that I last saw the deceased alive on _____ 11-25, 1958, and that death occurred at _____ 12:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Robert W. Trever PHYSICIAN'S NAME (Type) Robert W. TREVER		ADDRESS (Street, city or town, state) 202 Dover St. Easton, Md.						DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/28/58		22c. NAME OF CEMETERY OR CREMATORIAL Crompton Cemetery		22d. LOCATION (City, town, or county) Crompton		(State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE Elga L. Lane		ADDRESS Church Hill		24a. REC'D BY REGISTRAR DATE DEC 1 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Trever			

TO DENUNY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

18 FOR STATE
HEALTH DEPT.

19 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 18 Film 236 11-20-58 ans 12977 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12947

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Longwoods</i>		c. LENGTH OF STAY IN 1b <i>3 mo</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Longwoods, Md.</i>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Marta Gertrude Cecilia</i>		4. DATE OF DEATH <i>Nov. 12 1958</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>70.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH <i>July 15 1933</i>	8. DIVORCED <input type="checkbox"/> 9. AGE (In years from birthday) <i>25 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Post Mistress</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Post Office</i>	
11. BIRTHPLACE (State or foreign country) <i>Talbot, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Howard W. Sherwood Sr.</i>		14. MOTHER'S MARRIED NAME <i>Gertrude M. Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>314-30-7979</i> 17. INFORMANT <i>Geo. R. Cadehan</i> <i>Address</i> <i>Longwoods, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarct</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>Easton</i> (County) <i>Wicomico Co.</i> (State) <i>Md.</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Laura Whetley</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>WELTY</i>		DATE SIGNED <i>11-14-58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 15, 58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Longwood Cemetery</i>		22d. LOCATION (City, town, or county) <i>Easton</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>George R. Cadehan</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Francis</i> DATE <i>NOV 17 '58</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Francis</i>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12948

12946

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Talbot MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

EASTON 2 da. 21 hr.

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Memorial Hosp. tal

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Queen Anne

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Centreville 17X-2

d. STREET ADDRESS

203 Broadway -

e. IS RESIDENCE
ON A FARM?YES NO 3. NAME OF
DECEASED
(Type or print)

First William

Middle Lee

Last Clough

4. DATE
OF
DEATH

Month

Day

Year

19

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Sept. 22, 1884

9. AGE (In years
last birthday)

74 yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

10c. BIRTHPLACE (State or foreign country)

10d. CITIZEN OF WHAT COUNTRY?

10e. FATHER'S NAME

10f. MOTHER'S MAIDEN NAME

10g. ADDRESS

10h. WAS DECEASED EVER IN U. S. ARMED FORCES?

(If yes, give rank or dates of service)

10i. SOCIAL SECURITY NO.

10j. INFORMANT

10k. ADDRESS

10l. CAUSE OF DEATH (Enter only one cause per line, for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

541.0

DUE TO

Conditions, if any, which

gave rise to immediate

cause (a), stating the under-

lying cause first.

(b)

DUE TO

(c)

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY

PERFORMED?

YES NO INTERVAL BETWEEN
ONSET AND DEATH20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY Month, Day, Year

Hour o. m. 19

p. m.

20d. INJURY OCCURRED

While Not while

of work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from

19 to 19

alive on

and that death occurred at

12 PM

from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE

E.C.H. Schmidt

M.D.

219 S. Washington St

3 Nov 58

Centreville Maryland

22d. LOCATION (City, town, or county)

(State)

22e. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22f. DATE THEREOF

Nov 6 1958

22g. NAME OF CEMETERY OR CREMATORIUM

Chesterfield

22h. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

J. H. Bunting, Jr.

ADDRESS

Centreville, Maryland

24a. REC'D BY REGISTRAR

DATE NOV 6 '58

24b. REGISTRAR'S SIGNATURE

Arthur S. Khan

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12947

CERTIFICATE OF DEATH

Reg. Dist. No.

12949

1. PLACE OF DEATH a. COUNTY <i>Salisbury</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Maryland</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>29</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>40 Easton Maryland</i>						
3. NAME OF DECEASED (Type or print) <i>Elmer</i>		d. STREET ADDRESS <i>107 Goldsborough St.</i>						
First <i>H</i>		Middle <i>Collins</i>						
Last <i></i>		4. DATE OF DEATH <i>November 9</i>	Month Year <i>1958</i>					
5. SEX <i>Male</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-17-1889</i>					
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Night Clerk</i>		10b. KIND OF BUSINESS OR INDUSTRY						
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>						
13. FATHER'S NAME <i>Garrison R. Collins</i>		14. MOTHER'S MAIDEN NAME <i>Elmira Merrick</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>213-22-8582</i>						
17. INFORMANT <i>Mrs. Henry Purdy</i>		Address <i>Easton, Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs</i>						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332x</i>		DUE TO <i>Cerebral thrombosis</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b) cause (c)		DUE TO <i>(a) Left hemiplegia</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Easton</i>	(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>10/11</i> , 19 <i>58</i> , to <i>11/9</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>9/20</i> , 19 <i>58</i> , and that death occurred at <i>5:10 A.M.</i> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Thornton Harrison</i>				ADDRESS (Street, city or town, state) <i>Easton, Maryland</i>			DATE SIGNED <i>11/12/58</i>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 11, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Spring Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Easton, Maryland</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Maurice S. Neumann</i>		ADDRESS <i>2522 Easton, Md.</i>		24a. REC'D BY REGISTRAR <i>NOV 12 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Thornton Harrison</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF ALABAMA
DEPARTMENT OF REVENUE
CERTIFICATE OF DEBT

RECEIVED

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12948 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Reg. Dist. No. 12950
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY TALBOT		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY TALBOT		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN lb 1 1/2 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 EASTON		d. STREET ADDRESS 301 OAK AVE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Peggy		First June	Middle DIETER	Last DIETER	4. DATE OF DEATH NOV 22	Month NOV	Day 22	Year 1958
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1926	9. AGE (In years Jan. birthday) 32 32	IF UNDER 14 YEARS Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME C. C. Chilcutt		14. MOTHER'S MAIDEN NAME Estella Nan Trader						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. u kn		17. INFORMANT Sheldon E. Dietert		Address 301 Oak Ave. Sheldon E. Dietert, Easton, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Internal hemorrhage				INTERVAL BETWEEN ONSET AND DEATH		
816X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO (b) Ruptured spleen, hemothorax						
		DUE TO (c) Auto accident						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) pass in car involved in 2-car collision		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) road		20f. (City or town) nr Easton		
20c. TIME OF INJURY Hour o. m. 11-21 158		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. (County) Talbot		(State) Md.		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Nutrol causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Lewis Welty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 11-22-58		
EXAMINER'S NAME (Type) Welty								
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF 11/26/58		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Fort Lincoln		22d. LOCATION (City, town, or county) BLOOMSBURG, MD.		
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Krause				24a. REC'D BY REGISTRAR NOV 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Krause		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12945

12950

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	b. COUNTY <i>Queens Anne's</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>	c. LENGTH OF STAY IN 1b <i>15 hrs 10 min</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Queens Anne's</i>	d. STREET ADDRESS <i>Queens Anne's</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>	d. STREET ADDRESS		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>September 6 1938</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Painter</i>	11. BIRTHPLACE (State or foreign country) <i>Md. - Talbot Co.</i>	9. AGE (In years last birthday) yrs. <i>1</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	13. FATHER'S NAME (See Birth Cert.) <i>Clayton John Baynard</i>		
14. MOTHER'S MAIDEN NAME <i>Peggy Virginia Flamer</i>	(See Birth Cert.)		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>123-45-6789</i>	17. INFORMANT	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>493X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c) DUE TO <i>Pneumonia</i> <i>Malnutrition</i> <i>Dehydration</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i> <i>since birth</i> <i>2 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>Blow to head</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Easton</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>11-26-58</i> , 19 <i>58</i> , to <i>11-26-58</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>11-26-58</i> , 19 <i>58</i> , and that death occurred at <i>11:15 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>John E Baybutt</i> M.D. <i>205 Bayle Ave Easton</i> DATE SIGNED <i>12-1-58</i>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>11/30/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Commited Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Queens Anne's</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>James D. Darke</i>	ADDRESS <i>Easton, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>DEC 5 58</i>	24b. REGISTRAR'S SIGNATURE <i>James D. Darke</i>



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12949 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12951

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Delaware</i>	b. COUNTY <i>Kent Sussex</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>	c. LENGTH OF STAY IN 1b <i>DOA</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greenwood Bridgeville</i>	d. STREET ADDRESS <i>111</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>		e. DATE OF DEATH Month Day Year <i>November 12 1958</i>	
3. NAME OF DECEASED (Type or print) <i>Arthur M</i>	First <i>A</i>	Middle <i>rt</i>	4. DATE OF DEATH Month Day Year <i>November 12 1958</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>JUNE 17 1922</i>
9. AGE, IN YEARS (at birthday) <i>36</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Actor</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Job work</i>
10c. BIRTHPLACE (State or foreign country) <i>Delaware</i>		11. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John B. Fiori</i>	14. MOTHER'S MAIDEN NAME <i>Mary Mireider</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>	
16. SOCIAL SECURITY NO <i>W.W.II</i>		17. INFORMANT <i>W. Franklin Gould</i>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>816X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Multiple fractures of skull</i> <i>Automobile accident.</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <i>Automobile accident</i>
20c. TIME OF INJURY Month, Day, Year <i>11-12 1958</i>	20d. INJURY OCCURRED at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, Farm, factory, street, office building, etc.) <i>Par 404 West Beach</i>	20f. (City or town) <i>Denton</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Dawson D. George</i>	EXAMINER'S NAME (Type) <i>Dawson D. George</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <i>11-12-58</i>
22e. BURIAL, Cremation, or Removal (Specify) <i>BURIAL</i>	22f. DATE THEREOF <i>NOV. 15, 1958</i>	22g. NAME OF CEMETERY OR CREMATORIUM <i>Bridgeville</i>	22h. LOCATION (City, town, or county) <i>Bridgeville, Delaware</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Franklin Gould</i>	ADDRESS <i>Easton, MD</i>	24d. REC'D BY REGISTRAR DATE NOV 1 1958	24e. REGISTRAR'S SIGNATURE <i>Charles S. Evans</i>



1
FOR STATE
HEALTH DEPT.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12951 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12952

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN lb <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u>	
3. NAME OF DECEASED (Type or print) <u>James Leonard Forrest</u>		f. STREET ADDRESS <u>Morris Street</u>	
4. SEX <u>M</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Mar. 1, 1907</u>		9. DATE OF DEATH <u>November 20 1958</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
10c. BIRTHPLACE (State or foreign country) <u>Maryland</u>		11. AGE (In years from birthday) <u>51 yrs</u>	
13. FATHER'S NAME <u>Ernest B. Forrest</u>		14. MOTHER'S MAIDEN NAME <u>Elaine Pastors</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> 16. SOCIAL SECURITY NO. <u>219-16-1188</u> 17. INFORMANT <u>Mrs. Hazel Forrest</u> Address <u>Oxford, Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> DUE TO IMMEDIATE CAUSE (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d) <u>—</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u> 20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Lewis M. Welty</u> EXAMINER'S NAME (Type) <u>WELTY</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Nov. 23, 1958</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Oxford</u> 22d. LOCATION (City, town, or county) <u>Oxford, Maryland</u> (State) <u>—</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice F. Newnam Son</u> ADDRESS <u>Easton, Md</u>		24a. REC'D BY REGISTRAR <u>DAW 25 '58</u> 24b. REGISTRAR'S SIGNATURE <u>—</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12952 CERTIFICATE OF DEATH

Reg. Dist. No.

12953

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>		c. LENGTH OF STAY IN 1b <i>2 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>EASTON PERSONAL HOSPITAL</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>	
3. NAME OF DECEASED (Type or print) <i>George Harry Easton</i>		First <i>George</i>	Middle <i>Harry</i>
4. DATE OF DEATH <i>7/18/53</i>		Month <i>July</i>	Day <i>18</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH <i>July 18 1883</i>		9. AGE (in years last birthday) yrs. <i>76</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FARMER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>FARM</i>	11. BIRTHPLACE (State or foreign country) <i>England</i>
12. CITIZEN OF WHAT COUNTRY? <i>England</i>		13. FATHER'S NAME <i>John Robert Easton</i>	
14. MOTHER'S Maiden NAME <i>Emma Parsons</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>John Robert Easton</i>	Address <i>Easton Md</i>
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>155.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i> DUE TO <i>(c)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June</i> , 19 <i>47</i> , to <i>22 Nov</i> , 19 <i>53</i> , that I last saw the deceased alive on <i>21 Nov</i> , 19 <i>53</i> , and that death occurred at <i>12:00 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Easton, Maryland</i> DATE SIGNED <i>24 Nov 53</i>	
ACTUAL SIGNATURE <i>George Harry Easton</i>		PHYSICIAN'S NAME (Type) <i>THURSTON HARRISON</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov 24 53</i>	22c. NAME OF CEMETERY OR CINERARY <i>Spring Steel</i>
22d. LOCATION (City, town, or county) <i>Easton</i>		(State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>George Harry Easton</i>		24a. REC'D BY REGISTRAR <i>NOV 26 58</i>	24b. REGISTRAR'S SIGNATURE <i>George S. Means</i>
ADDRESS <i>1177 W. BROAD ST.</i>		DATE <i>NOV 26 58</i>	





1. DUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-trust permit. File pages 1 and 2 with the State Board of Health, or its designated office, prior to burial, cremation, or removal, and in any event within 24 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12978 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

ITEM 9 FILE 2, 6 12-12-58 ET

14232

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot	MARYLAND	2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Dorchester
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman	c. LENGTH OF STAY IN 1b 1 month	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS	

3. NAME OF DECEASED (Type or print) LEONARD	First	Middle	Lost	4. DATE OF DEATH FREENEY	Month	Day	Year
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5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 28, 1927	9. AGE (in years last birthday) 31 30	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Oyster Dredge	11. BIRTHPLACE (State or foreign country) Alachua County, Florida	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Fred Freeney	14. MOTHER'S MAIDEN NAME Lenia Hughes	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Alcoholism. - Exposure.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	
DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED?	
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>

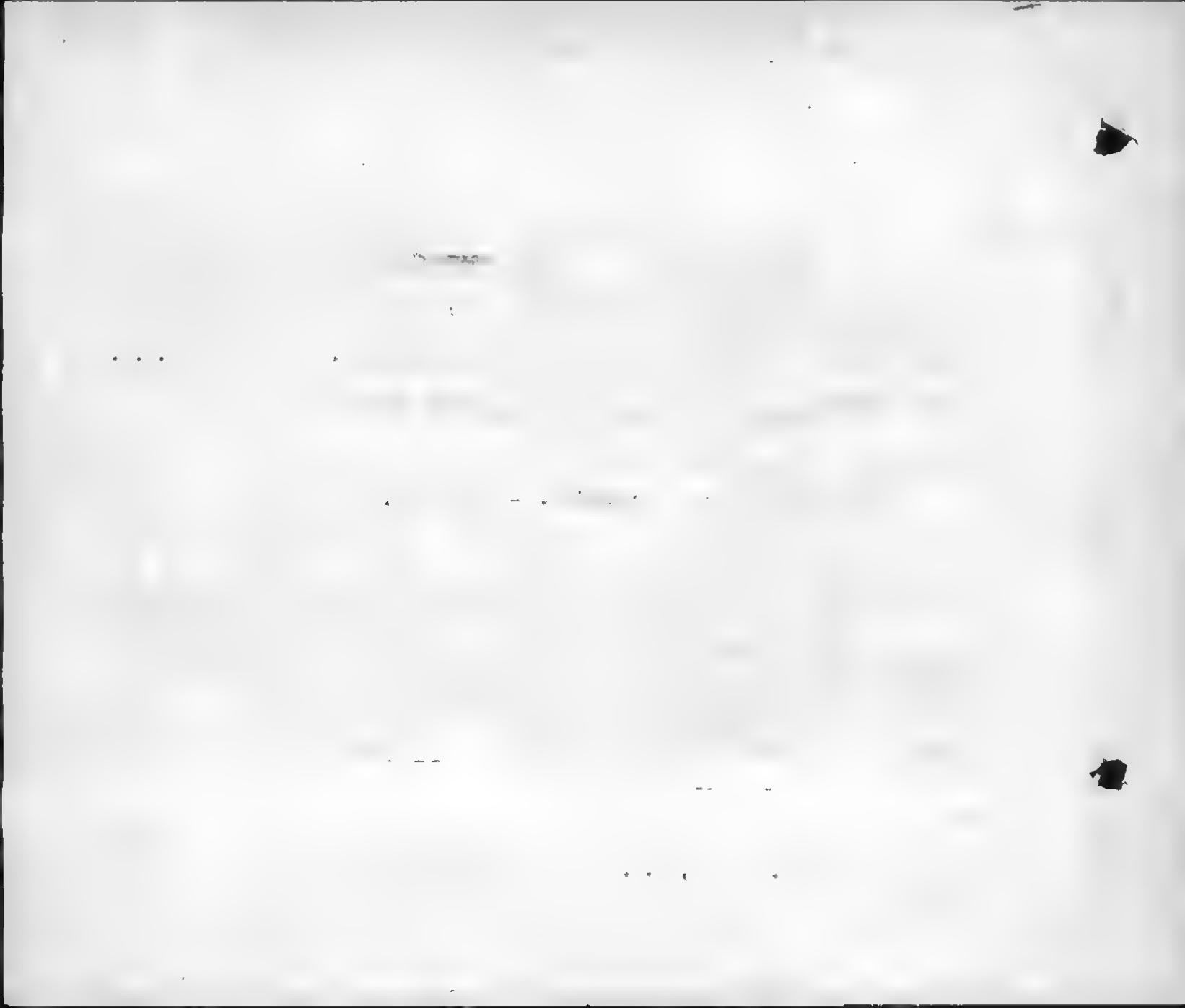
ACTUAL SIGNATURE <i>Paul F. Querin</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
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EXAMINER'S NAME (Type) Paul F. Querin, M.D.	ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
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22a. BURIAL, CREMATION OR REMOVAL (Specify) General	22b. DATE THEREOF 1-28-58	22c. NAME OF CEMETERY OR CREMATORIUM Holiday Springs	22d. LOCATION (City, town, or county) Holiday Springs, Fla.
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22e. REC'D BY REGISTRAR DEC 8 '58	22f. REGISTRAR'S SIGNATURE James S. Kline
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23. FUNERAL DIRECTOR'S SIGNATURE Marshall P. Burns 638 N. Glebe St.	ADDRESS Bethesda 17-mid
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12954

12955

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. STATE VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 3 mos 1958.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SOUTH & HARRISON STS. EASTON		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WEEMS	
3. NAME OF DECEASED (Type or print) MARIA		First LEE	Middle GOODWIN
4. DATE OF DEATH NOV. 27 1958		Month NOV.	Day 27
5. SEX Female		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH NOV. 9, 1884		9. AGE (In years last birthday) 74	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ROCKY MT. VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME EDWARD L. GOODWIN	
14. MOTHER'S MAIDEN NAME MARIA LOVE SMITH		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO.		17. INFORMANT MARY F. GOODWIN	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma of Breast		Address CHARLOTTESVILLE, VIRGINIA	
DUE TO 17.		INTERVAL BETWEEN ONSET AND DEATH 21 years.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1956 to Nov. 27, 1958 that I last saw the deceased alive on Nov. 27, 1958 , and that death occurred at 7:20 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Donald F. Bartley		ADDRESS (Street, city or town, state) 9 N. HANSON ST.	
PHYSICIAN'S NAME (Type) DONALD F. BARTLEY M.D.		DATE SIGNED 11-27-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVED		22b. DATE THEREOF NOV. 27, 1958	22c. NAME OF CEMETERY OR CREMATORIAL WEEMS
22d. LOCATION (City, town, or county) WEEMS		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE 11-27-58		ADDRESS 11-27-58	24a. REC'D BY REGISTRAR DATE DEC 8 '58
			24b. REGISTRAR'S SIGNATURE 11-27-58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

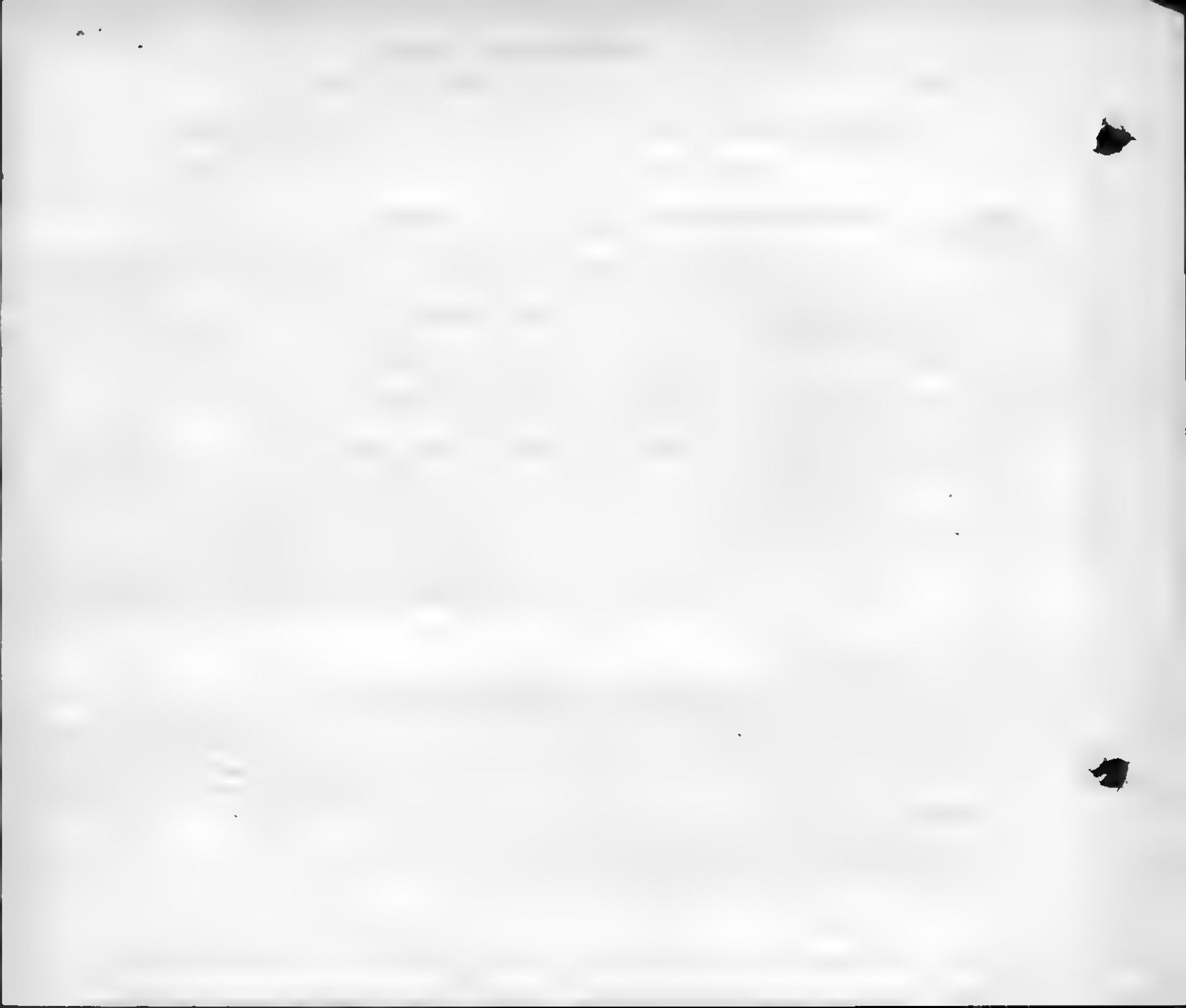
12953

CERTIFICATE OF DEATH

12954

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
Talbot MARYLAND		MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		c. LENGTH OF STAY IN 1b EASTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston	
Memorial Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		First Sherman	Middle T
4. DATE OF DEATH		Month 10	Day 7
5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 27, 1894	
9. AGE (in years at death) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin Griffith		14. MOTHER'S MAIDEN NAME Agnes Bardoe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Ruptured mitral valve Rheumatic mitral valvulitis	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 219 S. Washington St. 7 Nov 1958 DATE SIGNED	
ACTUAL SIGNATURE E.C.H. Schmidt		M.D.	
PHYSICIAN'S NAME (Type) E.C.H. Schmidt		22d. LOCATION (City, town, or county) Preston, Md. (State)	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 11-9-58	
22c. NAME OF CEMETERY OR CREMATORIAL Grove Cemetery		22d. LOCATION (City, town, or county) Preston, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Young W. Helms, Jr. PRE 5000 No.		24a. REC'D BY REGISTRAR DATE NOV 10 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12956

CERTIFICATE OF DEATH

14236

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town <i>Easton.</i>		c. LENGTH OF STAY IN lb <i>3 hrs. 40 min</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town <i>Queen Anne.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>McIvines</i>	Middle <i></i>	Last <i>Hawkins</i>	4. DATE OF DEATH	Month <i>November</i>	Day <i>26</i>	Year <i>1958</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>May 1896</i>	8. AGE (in years last birthday) <i>62 yrs.</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>	Hours <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Luther Young</i>		14. MOTHER'S MAIDEN NAME <i>Louisa Brown</i>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i></i>		16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO <i>Cerebral hemorrhage</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i></i>		(b) DUE TO <i></i>		(c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>hours</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i></i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) <i></i> (State) <i></i>	
21. I certify that I attended the deceased from <i>12 M</i> , 19 <i>58</i> , to <i>9 P</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>19</i> , and that death occurred at <i>Easton</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Kenis McIvines</i>		M.D. <i>IN E.L.V.</i>		ADDRESS (Street, city or town, state) <i>Easton Md.</i>		DATE SIGNED <i>12/1/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>11/30/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Easton, Md.</i>		22d. LOCATION (City, town, or county) (State) <i>Hillsboro Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Daugherty, Easton, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>DEC 10 1958</i>		24b. REGISTRAR'S SIGNATURE <i>12/10/58</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be given to
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12956

12955

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o STATE	
Talbot		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b EASTON 3 1/2 da	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Memorial Hospital x Royal Oak	
3. NAME OF DECEASED (Type or print)		First	Middle
Arthur		Freeman HALL	
4. DATE OF DEATH		Month	Day
		11	29
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
M		W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Dec 23, 1878
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS
97		Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
WATERMAN		SEAFOOD	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
MARYLAND		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Ernest Parker HALL		ANNA Kilmon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service)		16. SOCIAL SECURITY NO.	
No		213-22-4574	
17. INFORMANT		Address	
ALTON HALL, Royal Oak, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		3 days	
420.1		Hypocardiac Trigemintis	
DUE TO		Hypertensive Cardiovascular	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 Nov 1958, to 1958, that I last saw the deceased alive on 29 Nov 1958, and that death occurred at 8:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE R. Paul Shultz		DATE SIGNED 11-30-58	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		12-2-58	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)	
Springfield Cemetery		Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
J. Hambleton Harrison, St. Michaels		DATE DEC 3 '58	
		24b. REGISTRAR'S SIGNATURE	
		Arthur S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

12957

CERTIFICATE OF DEATH

12957

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>6 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Federalsburg</i>	
3. NAME OF DECEASED (Type or print) <i>Mildred</i>		First <i>H</i>	Middle <i>Jones</i>
4. DATE OF DEATH <i>November 19 1958</i>		Last	Month <i>November</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Nov. 5, 1896</i>		9. AGE (In years lost birthday) <i>62 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Isaac E. Hallowell</i>		14. MOTHER'S MAIDEN NAME <i>Maybelle Walker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>THURSTON JONES, FEDERALSBURG, MD</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatous - lymphatic & all organs</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>primary site unknown</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Nov. 19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <i>EASTON, MARYLAND</i>	
21. I certify that I attended the deceased from <i>Nov. 13, 1958</i> to <i>19 Nov 1958</i> , that I last saw the deceased alive on <i>19 Nov 1958</i> , and that death occurred at <i>11:22 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Thurston Harrison</i> M.D.		ADDRESS (Street, city or town, state) <i>EASTON, MARYLAND</i>	
22a. DATE SIGNED <i>20 Nov 58</i>		DATE SIGNED <i>20 Nov 58</i>	
22b. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>HILL CREST CEMETERY</i>	
22d. LOCATION (City, town, or county) <i>FEDERALSBURG, MARYLAND</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Chapman & Son, Federalsburg, Md.</i>		24a. ADDRESS <i>ADDRESS</i>	
24b. REGISTRAR'S SIGNATURE <i>C. J. S. Thorne</i>		24c. REC'D BY REGISTRAR <i>NOV 24 1958</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

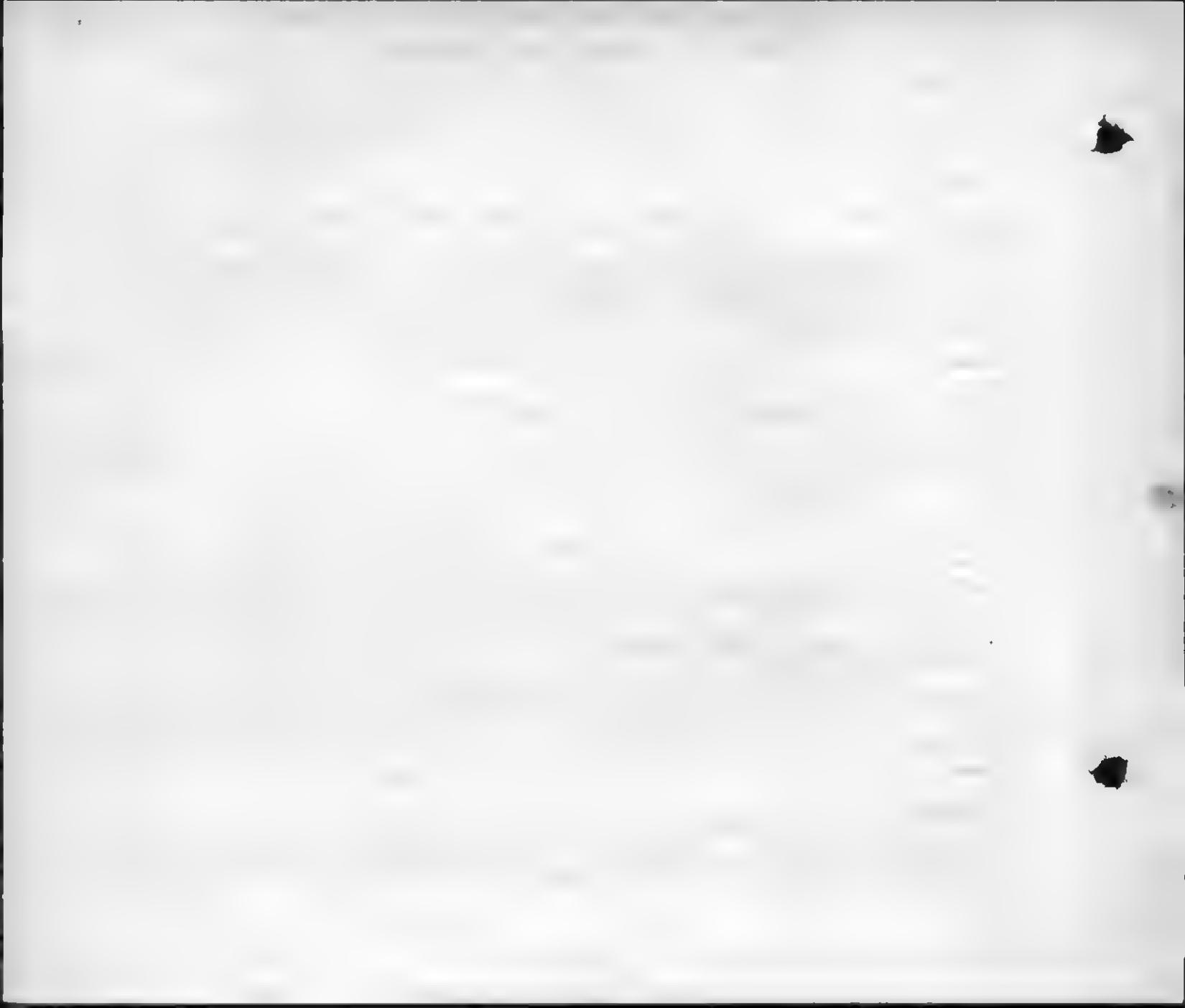
12958

CERTIFICATE OF DEATH

Reg. Dist. No.

12958

1. PLACE OF DEATH a. COUNTY <i>Albemarle</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Albemarle</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>6 da.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>		e. STREET ADDRESS <i>7 Main Street</i>	
3. NAME OF DECEASED (Type or print) <i>Hooper</i>		First <i>H.</i>	Middle <i>L.</i>
4. DATE OF DEATH <i>11/14/58</i>		Month <i>11</i>	Day <i>14</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>March 21 1898</i>		9. AGE (In years last birthday) <i>60 yrs</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waterman</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Fishing</i>	
11. BIRTHPLACE (State or foreign country) <i>Maplewood</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John K. Hooper</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>218-12-9147</i>	
17. INFORMANT <i>Mrs. Weller, Living - North East, Md</i>		Address <i>111 W. 10th Street</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>204.1</i> DUE TO as heart attack		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on <i>11/14/58</i> , and that death occurred at <i>2:30 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>219 S. Washington St., 1 Dec 58</i> DATE SIGNED <i>10/16/58</i>	
ACTUAL SIGNATURE <i>John K. Hooper</i>		M.D. <i>John K. Hooper</i>	
PHYSICIAN'S NAME (Type) <i>ECH Schaeffert</i>		C. 10/16/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/4/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Wesley Chapel Cem.</i>
22d. LOCATION (City, town, or county) (State)		22e. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William J. Williams</i>		ADDRESS <i>Westerly, Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>DEC 5 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Krause</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12959

CERTIFICATE OF DEATH

REPLACEMENT 14233
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton	c. LENGTH OF STAY IN lb 1 hr.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Royal Oak	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert Edward LeCompte	First	Middle	Last
4. DATE OF DEATH NOV. 5,	Month	Day	Year 1958
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1903
9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance	10b. KIND OF BUSINESS OR INDUSTRY metal	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edward LeCompte	14. MOTHER'S MAIDEN NAME Martha LeCompte	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) u kn	16. SOCIAL SECURITY NO. ---	17. INFORMANT Mrs. Gladys M. LeCompte, Royal Oak, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 45.2.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Myocardial Infarct Coronary occlusion	
		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) M.D.	(County)	(State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M., from the causes and on the date stated above ACTUAL SIGNATURE E.C.H. Schmidt		ADDRESS (Street, city or town, state) 2195. Washington St. 22 DATE SIGNED Easton, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/10/58	22c. NAME OF CEMETERY OR CREMATORIUM Spring Hill	22d. LOCATION (City, town, or county) Easton, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE C. Schmidt		24a. REC'D BY REGISTRAR DATE DEC 23 1958	24b. REGISTRAR'S SIGNATURE C. Schmidt

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12960 CERTIFICATE OF DEATH

12959
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		d. STREET ADDRESS 112 South Aurora ST			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital				d. STREET ADDRESS 112 South Aurora ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary		First A	Middle E	Lost 4. DATE OF DEATH November 14	Month 1958	Day 14	Year 1958		
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 12 1882	9. AGE (In years lost birthday) 76 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Henry Dean		14. MOTHER'S MAIDEN NAME Harriett Mina Dulin		Address 210-17-1102 Mr. C. J. Butler		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service)			
16. SOCIAL SECURITY NO 210-17-1102		17. INFORMANT Mr. C. J. Butler		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY (Month, Day, Year) Hour a. m. <input type="checkbox"/> p. m. <input checked="" type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.		ACTUAL TIME Morning		M.D.		ADDRESS (Street, city or town, state) EASTON, MARYLAND		DATE SIGNED 18 Nov 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Nov 7 58		22c. NAME OF CEMETERY OR CEMETORY Spring Hill		22d. LOCATION (City, town, or county) EASTON			
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Easton		ADDRESS EASTON, MD		24a. REC'D BY REGISTRAR NOV 19 '58		24b. REGISTRAR'S SIGNATURE Charles S. Turner			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Item 20 Film 236 12961 12961 12961 12961

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12960

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Charlottesville</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN lb <i>1 hr - 20 min</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Federal Hs Cemetery</i>		d. STREET ADDRESS <i>Brooklyn Ave</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>John Leroy McDaniell</i>		First <i>John</i>	Middle <i>Leroy</i>	Last <i>McDaniell</i>	4. DATE OF DEATH Month <i>11</i>	Month <i>7</i>	Day <i>19</i>	Year <i>58</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN. 15, 1910</i>	9. AGE (In years last birthday) <i>48</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. IF UNDER 24 HRS Hours <i>0</i>	13. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unemployed</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		12. ADDRESS <i>MARY R. McDANIEL, FEDERALSBURG, MD.</i>				
13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>MARY A. SMITH</i>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-16-1359</i>		17. INFORMANT <i>MARY R. McDANIEL</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>982X</i> Conditions, if any, which gave rise to immediate cause (b) of, stating the underlying cause (c) <i>DUE TO</i> <i>Stab wound through skull into brain</i>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <i>Stab wound through skull into brain</i>								
20c. TIME OF INJURY Hour <i>9:30 p.m.</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>At home</i>		(City or town) <i>Federal Hs Cemetery</i>	(County) <i>Caroline</i>	(State) <i>Md.</i>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>John D. George</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
EXAMINER'S NAME (Type) <i>DAWSON C. GEORGE MD</i>		DATE SIGNED <i>11-8-58</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 12, 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Federal Hs Cemetery</i>		22d. LOCATION (City, town, or county) <i>Federal Hs, Md.</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.J. Frangham Son</i>		ADDRESS <i>Federal Hs, Md.</i>		24a. REC'D BY REGISTRAR <i>NOV 13 '58</i>		24b. REGISTRAR'S SIGNATURE <i>John D. George</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12962

CERTIFICATE OF DEATH

Reg. Dist. No.

12961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Talbot MARYLAND		b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL EASTON		c. LENGTH OF STAY IN 1b 22 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Goldsboro	
Memorial Hospital		d. STREET ADDRESS C 5 X	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Wilbur			Melvin
4. DATE OF DEATH		Month	Day
		11	7
		Year	1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
M		W	8. DATE OF BIRTH Dec 12 1906
9. AGE (In years last birthday) YRS.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days
51			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
			Delaware
12. CITIZEN OF WHAT COUNTRY?		US A	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Hynson D. Melvin		Mary J. Martin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		10/18/58	
541.1		DUE TO	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		Peritonitis	
(b)		Perforated duodenal ulcer	
(c)		Chronic duodenal ulcer	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		10/18/58	
Chronic alcoholism		8 years?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County)	
		(State)	
21. I certify that I attended the deceased from <u>Sept 15, 1958</u> to <u>Nov 7, 1958</u> , that I last saw the deceased alive on <u>Nov 7, 1958</u> , and that death occurred at <u>9:20 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		DATE SIGNED	
ARTHUR B. CECIL JR.		11/8/58	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 9/1958	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Hebron
22d. LOCATION (City, town, or county) Hampton		(State) Va.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR DATE NOV 12 '58
Arthur S. Bouslaugh Greenbrier			24b. REGISTRAR'S SIGNATURE Arthur S. Kline



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12963

CERTIFICATE OF DEATH

12962

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Dorchester</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Nurlock</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Easton Memorial Hospital</i>				d. STREET ADDRESS						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)		First <i>Dorman</i>	Middle <i>W.</i>	Last <i>Messick</i>	4. DATE OF DEATH	Month <i>November</i>	Day <i>9</i>	Year <i>1958</i>		
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>August 22 1894</i>	9. AGE (In years last birthday) <i>64 yrs.</i>	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>	11. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		10c. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>Perry S. Messick</i>		14. MOTHER'S MAIDEN NAME <i>Clara Butler</i>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple sclerosis</i> DUE TO <i>1. d</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost! (b) <i>Ur. & leg.</i> (c) <i>Collegar disease type with ad</i>										
INTERVAL BETWEEN ONSET AND DEATH										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> p. m.							20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1958</i> to <i>1958</i> , that I last saw the deceased alive on <i>1958</i> , and that death occurred at <i>2133</i> M. from the causes and on the date stated above.									22. ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>C. H. Schmidt</i>									DATE SIGNED <i>219 S. King St. 218438</i>	
23. PHYSICIAN'S NAME (Type)		24a. BURIAL, CREMATION, REMOVAL (Specify) <i>11/6/58</i> 24b. DATE, THEREOF <i>11/6/58</i> 24c. NAME OF CEMETERY, OR CREMATORIAL <i>Washington Cemetery</i> 24d. LOCATION (City, town, or county) <i>Nurlock, Md.</i> (State)								
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harold Williams - Federalsburg Md.</i>		24e. ADDRESS 24f. REC'D. BY REGISTRAR DATE <i>NOV 12 '58</i> 24g. REGISTRAR'S SIGNATURE <i>John S. Jones</i>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be retained by the
funeral director, and page 3 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12979

CERTIFICATE OF DEATH

Reg. Dist. No.

12963

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wye</u>		c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wye</u>			
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>W</u>	Middle <u>FRANK</u>	Last <u>Newnam Jr</u>		
4. DATE OF DEATH	Month <u>Nov</u>	Year <u>1958</u>	Day <u>13</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 15/1875</u>		
9. AGE (In years last birthday) <u>83</u> yrs.	10. IF UNDER 1 YEAR <u>Months</u>	11. IF UNDER 24 HRS <u>Days</u>	12. IF UNDER 24 HRS <u>Hours</u>		
13. FATHER'S NAME <u>John S Newnam</u>	14. MOTHER'S MAIDEN NAME <u>Emily Shores</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO <u>220-32-086</u>	17. INFORMANT <u>Miss Edith Newnam</u>	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>002X</u> DUE TO <u>Pyrophysis</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Pulmonary Tuberculosis</u> DUE TO <u>36P.</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Dis.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Box 487, St. Michaels, Md</u>	(County) <u>1173-58</u>	(State)
21. I certify that I attended the deceased from <u>12/12/58</u> , to <u>12/12/58</u> , that I last saw the deceased alive on <u>12/12/58</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>K. Russell Holt</u>	ADDRESS (Street, city or town, state) <u>Box 487, St. Michaels, Md</u>			DATE SIGNED <u>12/12/58</u>	
PHYSICIAN'S NAME (Type) <u>Dr R. L. Newnam</u>	22. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Nov 15, 1958</u> 22c. NAME OF CEMETERY OR CREMATORIAL <u>Wye</u> 22d. LOCATION (City, town, or county) <u>Wye</u> (State) <u>Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newnam, Son</u>	ADDRESS <u>Easton, Md.</u>	24a. REC'D BY REGISTRAR <u>Arthur S. Krause</u>	24b. REGISTRAR'S SIGNATURE		
VS A15 (4) 15M 9/55	DATE <u>Nov 12 1958</u>	DATE <u>Nov 12 1958</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12980

CERTIFICATE OF DEATH

12964

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>St. Michaels, Md</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>		c. LENGTH OF STAY IN 1b <u>30 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>Thomas</u>		First <u>William</u>	Middle <u>Palmer</u>
4. DATE OF DEATH Month <u>Nov</u> Day <u>15</u> Year <u>1958</u>		5. SEX <u>male</u>	6. COLOR OR RACE <u>Colored</u>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Sept 30, 1884</u>		9. AGE (In years last birthday) yrs. <u>74</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
11. BIRTHPLACE (State or foreign country) <u>Bogman, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Elbert Palmer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Emma Moody</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-09-3261</u>	
17. INFORMANT <u>Mollie Palmer, St. Michaels, Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <u>Carcinoma of Prostate</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mon.</u> <u>14y.</u>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>St. Michaels</u> (County) <u>Md</u> (State) <u>1958</u>	
21. I certify that I attended the deceased from <u>12-16-57</u> , 1958, to <u>12-17-58</u> , 1958, that I last saw the deceased alive on <u>14 Aug</u> , 1958, and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Box 487, St. Michaels, Md</u> DATE SIGNED <u>11-17-58</u>			
ACTUAL SIGNATURE <u>R. Lane Whaley</u>		PHYSICIAN'S NAME (Type) <u>R. Lane Whaley</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 18, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORIUM <u>Memorial Park Cemetery, St. Michaels</u>		22d. LOCATION (City, town, or county) <u>St. Michaels</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Johnston Harrison</u>		24a. ADDRESS <u>St. Michaels, Md</u>	
24b. REGISTRAR'S SIGNATURE <u>Johnston Harrison</u>		24c. DATE <u>Nov 25, 1958</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be delivered far use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your information. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. AT 5ME
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12964 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12965

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY	Talbot		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution or residence before admission)	Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	EASTON		27 HR.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	EASTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Memorial Hospital		1531 S. Washington		1d. STREET ADDRESS	1 IS RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year
FRANK	Frederick	Foland	8-20-1895	63	Nov.	16	1958
5. SEX	6. COLOR OR RACE	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
M	W			8-20-1895	63		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
Research Eng-Revore Copper			MARYLAND		USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
Henry W. Poland			Clara Tousby				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT		
(If yes, give war or dates of service)			139-01-6302		- Mrs. Mary Poland -		
18. CAUSE OF DEATH (Enter only one cause per line) or (a), (b), and (c)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 900.0							
DUE TO Severe brain injury							
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.							
DUE TO Fall downstairs (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) EASTON Talbot Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Lenie WELTY</i>		DATE SIGNED 11-17-58					
EXAMINER'S NAME (Type) WELTY		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL/CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL <i>Archwood</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i> (State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. Frampton Carroll</i>		24a. ADDRESS <i>Easton, Md.</i>		24b. REC'D BY REGISTRAR <i>NOV 19 '58</i>		24c. REGISTRAR'S SIGNATURE <i>C. G. & H. T. T. G.</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12965

CERTIFICATE OF DEATH

12965

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be signed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Caroline</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>26 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Preston</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Easton Hospital Capital</i>		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>John</i>	Middle <i>Reese</i>	Last <i>Reese</i>	4. DATE OF DEATH	Month <i>November</i>	Day <i>21</i>	Year <i>1958</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>January 15 1899</i>	9. AGE (in years last birthday) <i>59 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Seamstress</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John W. Christopher</i>		14. MOTHER'S MAIDEN NAME <i>Louise Butler</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>John Reese, Preston</i>		Address <i>100</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Motions</i>		DUE TO <i>151X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 mo.</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) <i>Gastritis or Pneumonia</i>		12 mo.			
(c) <i>Gastritis & Stomach</i>				2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Po Box #158 Preston</i>		20f. (City or town) <i>Preston</i>	(County) (State) <i>Caroline Md</i>
21. I certify that I attended the deceased from <i>7/1</i> , 19 <i>76</i> , to <i>11/21</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>10/20</i> , 19 <i>58</i> , and that death occurred at <i>11:30 P.M.</i> , from the causes and on the date stated above.							
ACTUAL DATE <i>11/21/58</i>				ADDRESS (Street, city or town, state) <i>P.O. Box #158 Preston</i>		DATE SIGNED <i>11/21/58</i>	
PHYSICIAN'S NAME (Type) <i>Harold B. Plummer</i>							
22a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Buried Nov 24</i>		22b. DATE THEREOF <i>Nov 24</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Denton</i>		22d. LOCATION (City, town or county) <i>Denton</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.V. Moore & Son</i>		ADDRESS <i>Denton</i>		24a. REC'D BY REGISTRAR <i>Nov 28 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Civins & Sons</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12966

CERTIFICATE OF DEATH

12967

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>2 hrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		d. STREET ADDRESS <i>4210 Lockhaven Blvd.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Joseph</i>		First <i>VINCENT</i>	Middle <i>Reilly</i>	Last <i>Reilly</i>	4. DATE OF DEATH <i>November 13 1958</i>	Month <i>November</i>	Day <i>13</i>	Year <i>1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>4-4-1889</i>	9. AGE (In years last birthday) <i>69 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Railway Express Agency</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>JAMES REILLY</i>		14. MOTHER'S MAIDEN NAME <i>MARY JANE KENNEDY</i>		Address <i>Raven Blvd.</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>714-03-4045</i>		17. INFORMANT <i>Mrs. Gertrude E. Reilly, 4210 Loch</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart</i>		DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.</i>		DUE TO <i>(b)</i>		INTERVAL BETWEEN ONSET AND DEATH			
DUE TO <i>(c)</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		Month <i>Nov.</i>	Day <i>19</i>	Year <i>1958</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>M.D. 219 S Washington St. 1958</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>29, Md.</i>	(State) <i>1958</i>
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 9:40 P.M., from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>E. C. Schmidt</i>		ADDRESS (Street, city or town, State) <i>219 S Washington St. 1958</i>		DATE SIGNED <i>1958</i>					
PHYSICIAN'S NAME (Type) <i>E. C. Schmidt</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 18/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>New Cathedral</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i>	(State) <i>29, Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Witzke Funeral Directors</i>		ADDRESS <i>4101 Edmondson Ave</i>		24a. REC'D BY REGISTRAR <i>NOV 17 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Carroll & Tamm</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Log 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

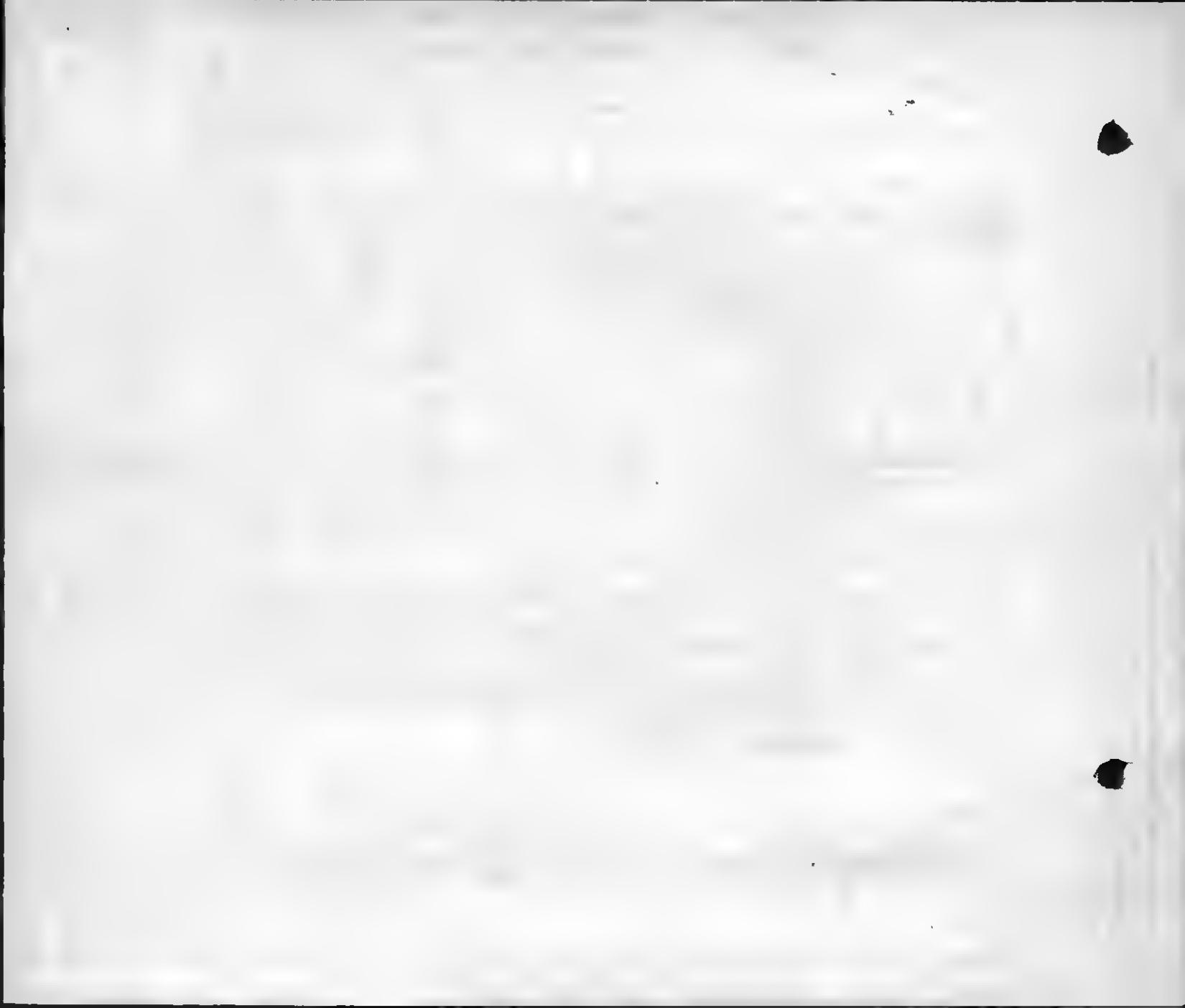
12967

CERTIFICATE OF DEATH

12968

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Caroline</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>31 da.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Denton</i>		d. STREET ADDRESS <i>515 Market St.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hospital</i>				d. STREET ADDRESS <i>515 Market St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>MARY</i>		First <i>A.</i>	Middle <i>Scotter</i>	Last <i>Scotter</i>	4. DATE OF DEATH <i>Nov. 24 1958</i>	Month <i>Nov.</i>	Day <i>24</i>	Year <i>1958</i>
5. SEX <i>f</i>		6. COLOR OR RACE <i>W</i>		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 1862</i>		9. AGE (in years lost birthday) <i>96 yrs</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Matthew Chilton</i>		14. MOTHER'S MOTHER'S NAME <i>Elizabeth Willis</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Matthew Chilton, Jr. D. Scorer</i>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i>		DUE TO <i>Arteriosclerosis, S. V. Disease.</i>				INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO <i>Fall of house</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Fall of house</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>Fall of house</i>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>EASTON, MARYLAND</i>		20f. (City or town) <i>EASTON, MARYLAND</i>	(County) <i>EASTON, MARYLAND</i>	
21. I certify that I attended the deceased from <i>10/24 1958</i> to <i>11/24 1958</i> , that I last saw the deceased alive on <i>19</i> , and that death occurred at <i>9 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Howard F. Kinnison</i>						ADDRESS (Street, city or town, state) <i>EASTON, MARYLAND</i>		
22a. BURIAL, CREMATION, REMOVAL (specify) <i>BURIAL NOV 27, 1958</i>		22b. DATE THEREOF <i>NOV 27, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>DENTON</i>		22d. LOCATION (City, town or county) <i>DENTON MD</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Virgil Moore & Son DENTON</i>		ADDRESS <i>DENTON</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 1 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Howard F. Kinnison</i>		



1
FOR STATE
HEALTH DEPT.

4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR Page 3 should be used as a burial-transit permit. Use pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and return to the Board within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12968

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12969

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 140	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		d. STREET ADDRESS 131 VINE ST	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Memorial Hospital		e. 1. RESIDENT ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Wesley		First Smith	Middle Smith
4. DATE OF DEATH Nov 12 1958		5. SEX male	6. COLOR OR RACE col
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 36 yrs.	
9. AGE (In years longer than 1 year) 36 yrs.		10. KIND OF BUSINESS OR INDUSTRY Laborer	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Smith		14. MOTHER'S MAIDEN NAME Mary Wisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Emmett Smith	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion		Address Easton, Md.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		INTERVAL BETWEEN ONSET AND DEATH immed.	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION LISTED IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) cirrhosis of liver	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Louis S. Welty</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Louis S. Welty		DATE SIGNED 11-12-58	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF 11/17/58	
22c. NAME OF CEMETERY OR CREMATORY <i>Lordstown Cem</i>		22d. LOCATION (City, town, or county) Easton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B. Doherty</i>		ADDRESS 426 Main Easton Md.	
24a. REC'D BY REGISTRAR NOV 12 1958		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Klaus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12969

CERTIFICATE OF DEATH

12970

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>F. A. Bot</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>MARYland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>EASTON</i>		c. LENGTH OF STAY IN 1b <i>4 da.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Federal's burg</i>	
3. NAME OF DECEASED (Type or print) <i>Barbara Christy, Jr.</i>		First <i>Barbara</i>	Middle <i>Christy</i>
4. DATE OF DEATH <i>11-2-58</i>		Last <i>Stanley</i>	Month Day Year 11 6 1958
5. SEX <i>F</i>		6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>11-2-58</i>		9. AGE (In years lost birthday) yrs. <i>4</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (State or foreign country) <i>MARYland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Maurice Stanley</i>		14. MOTHER'S MAIDEN NAME <i>Martha Ricketts</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>Maurice Stanley, FEDERALSBURG MD.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 da.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Cerebral Hemorrhages</i>		4 da	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11-2-58</i> to <i>11-6-58</i> , that I last saw the deceased alive on <i>11-6-58</i> , and that death occurred at <i>FEDERALSBURG MD.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>205 Earle Ave EASTON MD 11-8-58</i>	
ACTUAL SIGNATURE <i>John E Bayburt</i>		DATE SIGNED <i>11-8-58</i>	
PHYSICIAN'S NAME (Type) <i>John E Bayburt</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>NOV. 8, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>FEDERAL HILL CEMETERY</i>		22d. LOCATION (City, town, or county) <i>FEDERALSBURG, MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. Frumpton & Son, Federalsburg, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>NOV 13 '58</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Wm. S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12970

CERTIFICATE OF DEATH

Reg. Dist. No.

12971

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland		b. COUNTY		
Talbot				Maryland		Talbot				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 EASTON, Md.		d. STREET ADDRESS 68 Graham st		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 68 Graham st										
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
George Anna				Stanton	11	23	1958			
5. SEX Female		6. COLOR OR RACE Col		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/23/1913		9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Domestic		10c. BIRTHPLACE (State or foreign country) Maryland		10d. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Robert J. Banks		14. MOTHER'S MAIDEN NAME Charlotte Green								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		Acute myocardial infarction				INTERVAL BETWEEN ONSET AND DEATH Not stated				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO (b) Hypertensive cardiovascular Disease				YRS.				
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) EASTON		20f. (City or town) (County) MD		(State)		
21. I certify that I attended the deceased from _____		7/22, 1957, to _____		9/12, 1958		that I last saw the deceased alive on _____		ADDRESS (Street, city or town, state) EASTON		
ACTUAL SIGNATURE Shepard Krech Jr.								DATE SIGNED 11-25-58		
PHYSICIAN'S NAME (Type) Shepard Krech Jr.										
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF 11/26/58		22c. NAME OF CEMETERY OR CREMATORIAL Trappe, Cam		22d. LOCATION (City, town, or county) Trappe		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE James B. Banks		ADDRESS EASTON, Md.				24a. REC'D BY REGISTRAR NOV 28 '58		24b. REGISTRAR'S SIGNATURE Arl. 18. 1958		



REPLACEMENT CERTIFICATE FROM DR. WELTY. 12/2/58 - Film #236
mb/ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12972

CERTIFICATE OF DEATH

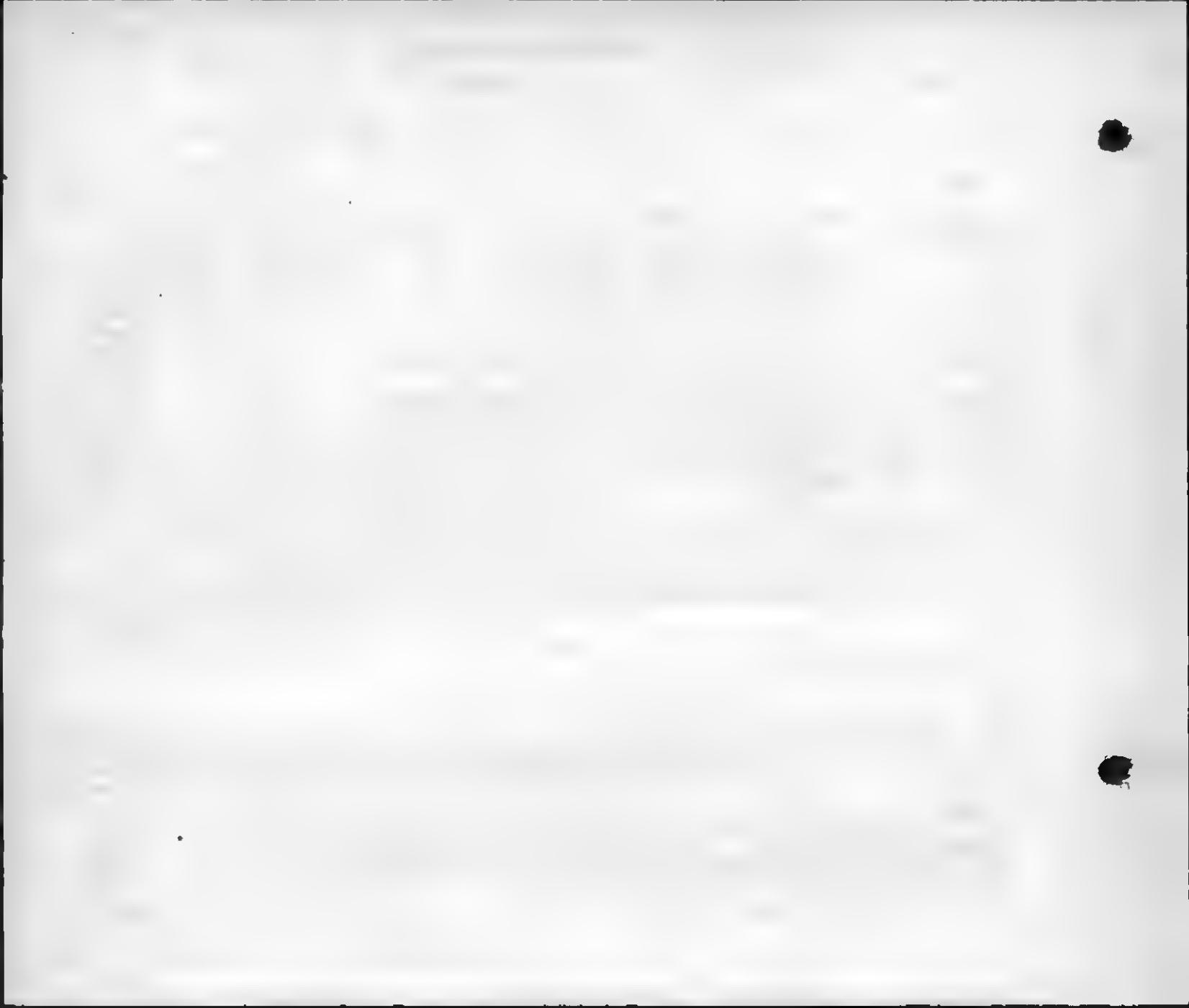
12973

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	c. LENGTH OF STAY IN lb <u>7 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u> 65x	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>		d. STREET ADDRESS <u>RIVER ROAD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>Paula</u>	Middle <u>Rashall</u>	Last <u>Strawberry</u>
4. DATE OF DEATH <u>November 27 1958</u>	Month <u>November</u>	Day <u>27</u>	Year <u>1958</u>
5. SEX <u>Female Colored</u>	6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>NOVEMBER 21 1938</u>
9. AGE (In years from last birthday) yrs <u>7</u>	10. IF UNDER 1 YEAR Months <u>7</u>	11. IF UNDER 24 HRS Days <u>7</u>	12. IF UNDER 24 HRS Hours <u>Min.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
10c. BIRTHPLACE (State or foreign country) <u>Maryland</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Leon Banks</u>		14. MOTHER'S MAIDEN NAME <u>Alice Joyce Strawberry</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ALICE J. STRAWBERRY, FEDERALSBURG, MD</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>760.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <u>Prematurity</u> 24123 (c)	
		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-21, 1958</u> to <u>11-27, 1958</u> , that I last saw the deceased alive on <u>11-26, 1958</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>205 S. 1st Ave</u> DATE SIGNED <u>12-1-58</u>			
ACTUAL SIGNATURE <u>John E. Baybutt</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>DEC. 8, 1958</u> 22c. NAME OF CEMETERY OR CREMATORIUM <u>FEDERAL HILL CEMETERY FEDERALSBURG, MD.</u> 22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Hamilton & Son Federalsburg</u>		24a. RECED BY REGISTRAR <u>DEC 8 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>
25.016/XVI			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 1 12-12-25 11-12-50 et
12903 CERTIFICATE OF DEATH

Req. Dist. No.

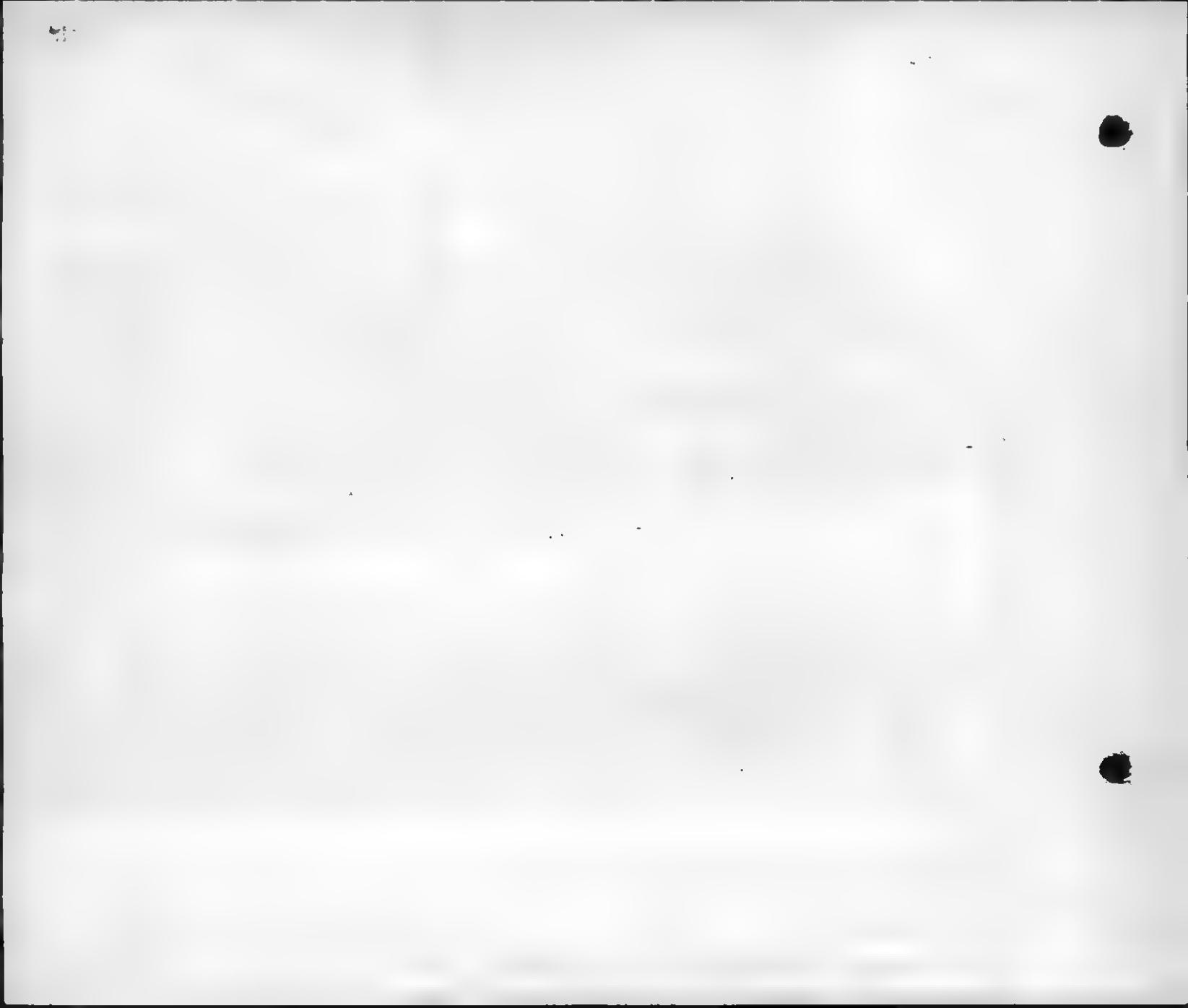
12904

1. PLACE OF DEATH o COUNTY <u>TALBOT</u>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MARYLAND</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>		c. LENGTH OF STAY IN 1b <u>12 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X ST. MICHAELS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At home			d. STREET ADDRESS <u>1204 CHEW AVE</u>		
e. S RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>WILLIAM</u>		First <u>H.</u>	Middle <u>Summfield</u>	Last	4. DATE OF DEATH <u>Nov 5 1958</u>
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 30 1889</u>	9. AGE (In years lost birthday) <u>69 yrs</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TATTOOLMAN, Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Phila Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>WILLIAM H. SUMMFIELD</u>			14. MOTHER'S MAIDEN NAME <u>CHARLOTTE Diddings</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WWI</u>			16. SOCIAL SECURITY NO. <u>214-30-95664</u>		
17. INFORMANT <u>Laura E. Summfield, St. Michaels</u>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Initial Pulmonary Edema 6 min</u> <u>Coronary Artery Disease 7 years</u> <u>Arteriosclerosis (Generalized) 8 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]		
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>St. Michaels</u> , 1906, to <u>5 Nov 1958</u> , that I last saw the deceased alive on <u>5 Nov 1958</u> , and that death occurred on <u>10 Nov 1958</u> AM, from the causes and on the date stated above. ADDRESS (Street, City or town, state) <u>Box 487, St. Michaels, Md 21665</u>					
DATE SIGNED <u>10 Nov 1958</u>					
ACTUAL SIGNATURE <u>R. Kane Wrotte</u>			PHYSICIAN'S NAME (Type) <u>Physician, St. Michaels</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM <u>Hillside Cemetery</u>	
				22d. LOCATION (City, town, or county) <u>Roslyn</u> , (State) <u>Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Hamletton Harrison, St. Michaels</u>			24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>		
ADDRESS <u>1204 Chew Ave, St. Michaels</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

INTENDING FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. **NOTE 4**

may be retained by the hospital or attending physician as an official record. This certificate has been signed by the attending physician and completely filled in by the funeral director. **NOTE 5**

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12973

CERTIFICATE OF DEATH

12974

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 6 days.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTON Memorial Hosp.		e. STREET ADDRESS Ridgely	
3. NAME OF DECEASED (Type or print) Dennis		First D	Middle T.
4. DATE OF DEATH thomas		Lost	Month 11 - Day 13 - Year 1958
5. SEX Male.		6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH July 15, 1880		9. AGE (In years last birthday) 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Fred		14. MOTHER'S M AIDEN NAME Mary	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Class Huff, daughter - Ridgely, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 224X		INTERVAL BETWEEN ONSET AND DEATH months	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b)		?	
DUE TO (c)		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 11/13 (County) (State)	
21. I certify that I attended the deceased from 11/17/58 to 11/13/58 , that I last saw the deceased alive on 11/13/58 , and that death occurred at 8 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) EASTON, MD DATE SIGNED 11/13/58			
ACTUAL SIGNATURE P. E. Cox		M.D.	
PHYSICIAN'S NAME (Type) P. E. Cox MD		EASTON, MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/16/58	
22c. NAME OF CEMETERY OR CREMATORIAL Shenandoah Memorial Cemetery Ridgely, Md.		22d. LOCATION (City, town, or county) (State) Ridgely, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Krause		ADDRESS	
24a. REC'D BY REGISTRAR DATE NOV 19 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12974

CERTIFICATE OF DEATH

Reg. Dist. No.

12975

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland		b. COUNTY		Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural		d. STREET ADDRESS		-	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		EASTON MEMORIAL HOSP.		d. STREET ADDRESS		-		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	Min.		
M		COL.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	OCT. 1866	92						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
FARMER		Retired		Maryland		U.S.A.					
13. FATHER'S NAME		Townsend		14. MOTHER'S MAIDEN NAME		Frances Kellum					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
(If yes, give war or dates of service)						Mrs. Gertrude Cooper, Easton, Md					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Pneumonia, right lung		INTERVAL BETWEEN ONSET AND DEATH					
		493X		DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)									
		DUE TO									
		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Advanced arteriosclerosis.									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from alive on		19		to		19		, 19		, 19	
ACTUAL SIGNATURE		E. C. H. Schmidt		M.D.		2195 West 117th St.		5X 10 Nov 58		DATE SIGNED	
NAME (Type)		E. C. H. Schmidt		E. C. H. Schmidt		E. C. H. Schmidt		E. C. H. Schmidt		E. C. H. Schmidt	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)					
Burial		11/15/58		Unionville Cem.		E. C. H. Schmidt		E. C. H. Schmidt			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
James D. Grashell, Boston, Md.				NOV 19 58		Wm. S. Mull					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12975

CERTIFICATE OF DEATH

12976

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE	
Talbot		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Frost		5 hrs 37 min	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
Memorial Hospital		Ridgely Md.	
f. FIRST MIDDLE LAST		g. DATE OF DEATH	
James K. Woodward		Nov. 29 1958	
h. COLOR OR RACE		i. DATE OF BIRTH	
Male White		Dec. 3, 1933	
j. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		k. AGE (In years lost birthday)	
		24 yrs.	
l. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		m. KIND OF BUSINESS OR INDUSTRY	
DR. Painter		None	
n. BIRTHPLACE (State or foreign country)		o. CITIZEN OF WHAT COUNTRY?	
MARYLAND		U.S.A.	
p. FATHER'S NAME		q. MOTHER'S MAIDEN NAME	
Mr. James Clark Woodward		Leona Marvel	
r. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		s. SOCIAL SECURITY NO.	
No		217-30-9246	
t. INFORMANT		u. ADDRESS	
Janet Woodward Ridgely Md.			
v. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		w. INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Sub-ovarian & intra-ventricular	
330 X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) Hemorrhage due to ruptured cystic artery	
(c) congenital aneurism			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		x. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
y. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		z. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M.D. ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE		219 S. Washington St. 29 Nov 58	
PHYSICIAN'S NAME (Type)		E.C. Schmidt Frost, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		12/1/58	
22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		22d. LOCATION (City, town, or county) (State)	
J.E. Boe lais Greensboro, Md.		Hawthorne Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
J.E. Boe lais Greensboro, Md.		DATE DEC 2 '58	
24b. REGISTRAR'S SIGNATURE		Arthur S. Kraus	

STATE OF HAWAII—DIVISION OF HUMAN RESOURCES
CERTIFICATE OF DATA

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12976

CERTIFICATE OF DEATH

Reg. Dist. No.

12977

1. PLACE OF DEATH a. COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Talbot</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. LENGTH OF STAY IN 1b <i>20 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		d. STREET ADDRESS <i>Rt # 3 Box 45</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Memorial Hosp.</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Mattie</i>		First	Middle	Last	4. DATE OF DEATH <i>Young</i>	Month	Day	Year	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 9, 1875</i>	9. AGE (In years from last birthday) <i>83</i> yrs.	10. IF UNDER 1 YEAR Month <i>1</i>	11. IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Solomon Wilson</i>		14. MOTHER'S MARRIED NAME <i>Isabelle</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>157X</i>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Adenocarcinoma of Pancreas</i> DUE TO 157X		Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on <i>July 19</i> , 19 <i>58</i> , to <i>July 19</i> , 19 <i>58</i> , that I last saw the deceased and that death occurred at <i>4:30 AM</i> , from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <i>219 S. Washington St. 20 Nov 58</i>	
ACTUAL SIGNATURE <i>E.C.H. Schmidt</i>		DATE SIGNED <i>20 Nov 58</i>							
PHYSICIAN'S NAME (Type) <i>E.C.H. Schmidt</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11/24/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Joy Town Cem.</i>		22d. LOCATION (City, town, or county) <i>Easton</i>		(State) <i>Rt 3, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James B Dashfield</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>Arthur S. Thane</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thane</i>		DATE NOV 28 '58	

CERTIFICATE OF DEBT

THE STATE OF MASSACHUSETTS - BOSTON

DEBT	AMOUNT	TERM	INTEREST	COLLECTOR	RECEIVED
1	\$100.00	12 months	12%	John Doe	10/10/2023
2	\$200.00	18 months	15%	John Doe	10/10/2023
3	\$300.00	24 months	18%	John Doe	10/10/2023
4	\$400.00	30 months	21%	John Doe	10/10/2023
5	\$500.00	36 months	24%	John Doe	10/10/2023
6	\$600.00	42 months	27%	John Doe	10/10/2023
7	\$700.00	48 months	30%	John Doe	10/10/2023
8	\$800.00	54 months	33%	John Doe	10/10/2023
9	\$900.00	60 months	36%	John Doe	10/10/2023
10	\$1000.00	66 months	39%	John Doe	10/10/2023
11	\$1100.00	72 months	42%	John Doe	10/10/2023
12	\$1200.00	78 months	45%	John Doe	10/10/2023
13	\$1300.00	84 months	48%	John Doe	10/10/2023
14	\$1400.00	90 months	51%	John Doe	10/10/2023
15	\$1500.00	96 months	54%	John Doe	10/10/2023
16	\$1600.00	102 months	57%	John Doe	10/10/2023
17	\$1700.00	108 months	60%	John Doe	10/10/2023
18	\$1800.00	114 months	63%	John Doe	10/10/2023
19	\$1900.00	120 months	66%	John Doe	10/10/2023
20	\$2000.00	126 months	69%	John Doe	10/10/2023
21	\$2100.00	132 months	72%	John Doe	10/10/2023
22	\$2200.00	138 months	75%	John Doe	10/10/2023
23	\$2300.00	144 months	78%	John Doe	10/10/2023
24	\$2400.00	150 months	81%	John Doe	10/10/2023
25	\$2500.00	156 months	84%	John Doe	10/10/2023
26	\$2600.00	162 months	87%	John Doe	10/10/2023
27	\$2700.00	168 months	90%	John Doe	10/10/2023
28	\$2800.00	174 months	93%	John Doe	10/10/2023
29	\$2900.00	180 months	96%	John Doe	10/10/2023
30	\$3000.00	186 months	99%	John Doe	10/10/2023
31	\$3100.00	192 months	102%	John Doe	10/10/2023
32	\$3200.00	198 months	105%	John Doe	10/10/2023
33	\$3300.00	204 months	108%	John Doe	10/10/2023
34	\$3400.00	210 months	111%	John Doe	10/10/2023
35	\$3500.00	216 months	114%	John Doe	10/10/2023
36	\$3600.00	222 months	117%	John Doe	10/10/2023
37	\$3700.00	228 months	120%	John Doe	10/10/2023
38	\$3800.00	234 months	123%	John Doe	10/10/2023
39	\$3900.00	240 months	126%	John Doe	10/10/2023
40	\$4000.00	246 months	129%	John Doe	10/10/2023
41	\$4100.00	252 months	132%	John Doe	10/10/2023
42	\$4200.00	258 months	135%	John Doe	10/10/2023
43	\$4300.00	264 months	138%	John Doe	10/10/2023
44	\$4400.00	270 months	141%	John Doe	10/10/2023
45	\$4500.00	276 months	144%	John Doe	10/10/2023
46	\$4600.00	282 months	147%	John Doe	10/10/2023
47	\$4700.00	288 months	150%	John Doe	10/10/2023
48	\$4800.00	294 months	153%	John Doe	10/10/2023
49	\$4900.00	300 months	156%	John Doe	10/10/2023
50	\$5000.00	306 months	159%	John Doe	10/10/2023
51	\$5100.00	312 months	162%	John Doe	10/10/2023
52	\$5200.00	318 months	165%	John Doe	10/10/2023
53	\$5300.00	324 months	168%	John Doe	10/10/2023
54	\$5400.00	330 months	171%	John Doe	10/10/2023
55	\$5500.00	336 months	174%	John Doe	10/10/2023
56	\$5600.00	342 months	177%	John Doe	10/10/2023
57	\$5700.00	348 months	180%	John Doe	10/10/2023
58	\$5800.00	354 months	183%	John Doe	10/10/2023
59	\$5900.00	360 months	186%	John Doe	10/10/2023
60	\$6000.00	366 months	189%	John Doe	10/10/2023
61	\$6100.00	372 months	192%	John Doe	10/10/2023
62	\$6200.00	378 months	195%	John Doe	10/10/2023
63	\$6300.00	384 months	198%	John Doe	10/10/2023
64	\$6400.00	390 months	201%	John Doe	10/10/2023
65	\$6500.00	396 months	204%	John Doe	10/10/2023
66	\$6600.00	402 months	207%	John Doe	10/10/2023
67	\$6700.00	408 months	210%	John Doe	10/10/2023
68	\$6800.00	414 months	213%	John Doe	10/10/2023
69	\$6900.00	420 months	216%	John Doe	10/10/2023
70	\$7000.00	426 months	219%	John Doe	10/10/2023
71	\$7100.00	432 months	222%	John Doe	10/10/2023
72	\$7200.00	438 months	225%	John Doe	10/10/2023
73	\$7300.00	444 months	228%	John Doe	10/10/2023
74	\$7400.00	450 months	231%	John Doe	10/10/2023
75	\$7500.00	456 months	234%	John Doe	10/10/2023
76	\$7600.00	462 months	237%	John Doe	10/10/2023
77	\$7700.00	468 months	240%	John Doe	10/10/2023
78	\$7800.00	474 months	243%	John Doe	10/10/2023
79	\$7900.00	480 months	246%	John Doe	10/10/2023
80	\$8000.00	486 months	249%	John Doe	10/10/2023
81	\$8100.00	492 months	252%	John Doe	10/10/2023
82	\$8200.00	498 months	255%	John Doe	10/10/2023
83	\$8300.00	504 months	258%	John Doe	10/10/2023
84	\$8400.00	510 months	261%	John Doe	10/10/2023
85	\$8500.00	516 months	264%	John Doe	10/10/2023
86	\$8600.00	522 months	267%	John Doe	10/10/2023
87	\$8700.00	528 months	270%	John Doe	10/10/2023
88	\$8800.00	534 months	273%	John Doe	10/10/2023
89	\$8900.00	540 months	276%	John Doe	10/10/2023
90	\$9000.00	546 months	279%	John Doe	10/10/2023
91	\$9100.00	552 months	282%	John Doe	10/10/2023
92	\$9200.00	558 months	285%	John Doe	10/10/2023
93	\$9300.00	564 months	288%	John Doe	10/10/2023
94	\$9400.00	570 months	291%	John Doe	10/10/2023
95	\$9500.00	576 months	294%	John Doe	10/10/2023
96	\$9600.00	582 months	297%	John Doe	10/10/2023
97	\$9700.00	588 months	300%	John Doe	10/10/2023
98	\$9800.00	594 months	303%	John Doe	10/10/2023
99	\$9900.00	600 months	306%	John Doe	10/10/2023
100	\$10000.00	606 months	309%	John Doe	10/10/2023